**NHS Education for Scotland**

**Equality Impact Assessment Report**

**Name of function, policy or programme:** ReSPECT – anticipatory care planning

**NES directorate or department:** NES Digital Service (NDS)

**Name of person(s) completing EQIA:** Helen New, Nicholas Hay, Blythe Robertson

**Individuals or groups contributing to EQIA:** Doug Kidd, Steve Pavis, Kristi Long, Alistair Ewing, Rohan Gunatillake, Andrew McCallum, Juliet Spiller, NHS Forth Valley implementation team

**Date Report Completed:** February 2020

**1. Define the function[[1]](#footnote-2)**

1. The National Digital Platform (NDP) seeks to enhance anticipatory care planning across Scotland by ensuring the right information is available to the right people, in the right way, at the right time. As a first step, the NDP will support the ReSPECT process (Recommended Summary Plan for Emergency Care and Treatment) by digitising the information captured during a conversation between a patient and their family and their clinician/care team (both in primary and secondary care) about their wishes relating realistic emergency care and treatment options. To fully support anticipatory care planning, the up-to-date information captured during ReSPECT process should be available across health and social care: within the hospital (for acute or emergency care), within the community (within GP, care home, hospice or social care), more broadly (from Out-Of-Hours GP cover, district nursing, Scottish Ambulance Service, NHS24) and directly to citizens themselves.
2. The NES Digital Service (NDS) has developed the application to support the ReSPECT process. NDS will act as the data processors on behalf of health boards connected to the NDP, which in the first instance is NHS Forth Valley.
3. The Forth Valley project will proceed through a phased approach:

* Phase 1 involves the digitisation of the current paper ReSPECT form, with storage on the NES Digital Platform on a Cloud infrastructure. Data input will be by the clinical team, initially within secondary care but quickly expanding to include community clinicians such as General Practitioners and nurse specialists.

* Phase 2 will involve facilitating read and write access to GP practices (primary care clinical and practice administration staff).

* Phase 3 will involve wider access to professionals involved in the patient’s care within the community (examples include Scottish Ambulance Service, Out of Hours Services, hospice and care home staff).

* Phase 4 will involve providing access to patients and legal proxies

1. The current EQIA will relate to **phases 1 and 2**, with further examination of how the digital solution best supports shared decision-making conversations made prior to the commencement of phases 3 and 4.

**2. Evidence used to inform assessment**

1. The focus of evidence gathering has been across three areas: the ReSPECT process itself, including its current implementation as a paper process in NHS Forth Valley; digital inequalities more generally; and the interplay between redesigning health processes and supporting them with digital solutions.
2. The ReSPECT process was developed by the Resuscitation Council (UK) in partnership with the [Helix Centre](https://helixcentre.com/project-respect). Its development was highly collaborative with a human-centred design approach taken. While the output of the work was a new form, the overall project redesigned the process for capturing people’s wishes for future emergency care, with a shared decision-making conversation at the heart of it. This facilitates patient and family involvement in CPR decision making in alignment with the existing medico-legal framework.
3. ReSPECT process, as well as wider ACP approach, has the potential to open up discussions for people who are vulnerable and ordinarily could be at risk of being excluded from being involved in discussions about their care. It can be an important tool to advocate for vulnerable people’s needs or wishes, when they may be faced with an emergency situation but not necessarily have an advocate present.
4. ReSPECT was subject to equalities impact activity during its formation. Rather than this resulting in the publication of an EQIA (or similar), the approach taken focussed on legislative compliance given the context of legal challenge around this area of healthcare practice.
5. The approach is both practically focussed and brings a rigour to the legal and practice context in which the ReSPECT process is operating. It reaches a clear conclusion that:

“the ReSPECT form and the process more generally which will give rise to the completion of a form in any given case that complies with the relevant legal requirements set down both in domestic law and the ECHR [European Convention on Human Rights]. They seek to place patients (and their proxies/those close to them where they lack capacity) at the core of a process to guide what treatment is to be given in an emergency situation, and, if implemented, will to that extent bring what should already be good clinical practice clearly into line with the governing principles developed by the courts.”

1. While this advice primarily relates to the context of England and Wales, it is reinforced by legal statements from Scotland’s Mental Welfare Commission.
2. To understand the current ReSPECT process work in Forth Valley, we interviewed representatives from the clinical team that are leading the work. They have all been involved in the design and delivery of the product so have positively contributed to ensuring the application best meets their clinical needs and is responsive to their digital skill level.
3. We examined how the application would meet widely understood and adopted accessibility standards.
4. We undertook research on available materials related to digital inequalities.
5. We also examined design approaches that form part of the wider work of NDS and have been a key part of the ReSPECT product development.

**3. Results from analysis of evidence and engagement**

1. Equalities issues have often been poorly considered by digital and technology programmes across the public sector. While there is strong understanding and adherence to equalities legislation and regulation at organisational level, the fragmentation of the approach to technology development – as identified in reports such as the [Expert Panel report](https://www2.gov.scot/Resource/0053/00534667.pdf) on digital health and care in Scotland – has led to a lack of clarity on who is responsible for maintaining high standards of accessibility. The NES Digital Service’s approach to bringing greater consistency to digital services for health and social care means it has an excellent opportunity to address this.

**Health literacy**

1. The work of NDS will take a health literacy responsive approach. This is in line with the [New Scots](https://www.gov.scot/publications/new-scots-refugee-integration-strategy-2018-2022/pages/11/) strategy on refugee integration, as well as the wider health literacy action plan, [*Making it Easier*](https://www2.gov.scot/Resource/0052/00528139.pdf)*.*

**Protected characteristics**

1. Equalities impact for the following protected groups was considered as part of the ReSPECT development:
* age
* Disability (for example
* gender reassignment
* marriage and civil partnership
* pregnancy and maternity
* race
* religion or belief
* sex
* sexual orientation

1. Further cross-cutting issues were included in considerations captured in the Forth Valley equalities impact (included at Annex A) of the ReSPECT process:

* staff
* carers
* homeless
* involved in criminal justice system
* language/social origins
* literacy
* low income/poverty
* mental health problems
* rural areas
* armed services veterans, reservists and former members of reserve forces

**Usage of digital solutions**

1. For age, a recent [Office of National Statistics report](https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2019) says that 47% of adults aged 75 years and over were recent internet users, set against 95% of adults aged 16 to 74 years. This highlights a fact that lower digital usage is linked to increasing age.
2. In terms of disability, the same report says that the number of disabled adults who were recent internet users reached over 10 million for the first time. This represents 78% of disabled adults. We need to factor-in how well represented people living with conditions such as dementia are in disability adult statistics. This may reflect a much lower percentage than that quoted in this study. In addition, as statistics emerge from various initiatives supporting citizen access to health information and services, these may provide more accurate and/or relevant evidence.

**Additional communications needs**

1. The ReSPECT process identifies and documents communication needs, for example the need for hearing aids or interpreters. It also identifies the presence of mental incapacity and identifies proxy decision makers. This could further ensure potentially vulnerable patients have their views and wishes fairly represented.

**Religious beliefs**

1. While religious belief plays a strong role in general attitudes to health and care and specifically to perceptions to death and end of life care, it is less clear that digital approaches to support this area of practice have a significant positive or negative impact.
2. Through interactions with the clinical team in NHS Forth Valley, we learned of at least one case where sensitive religious views had to be considered as part of the ReSPECT process. This case also included the need for interpreter services. This was handled in a highly responsive and sensitive way and gave good insight into how future cases of this type should be approached.

**Translation services**

1. A further example was given where translation services were provided by a family member who struggled to convey the full extent of the patient’s condition. This highlighted the need for appropriate translation services – an aspect that is already recommended practice across NHS Forth Valley – particularly to ensure that no undue burden is placed on caregivers.

**Involvement and inclusivity in the ReSPECT process**

1. We learned that Forth Valley’s wider work on anticipatory care planning, of which the ReSPECT process is a strand, has been developed with health literacy responsiveness in mind. The Forth Valley ReSPECT implementation group has equality, diversity and co-design as one of its workstreams. Forth Valley also conducted a qualitative component to evaluation with patients and carer feedback. The played a strong role in shaping the roll out of the ReSPECT process and should be a key consideration in the digital evaluation. Patient representatives are included on the Forth Valley implementation group.
2. ReSPECT at its core is about a conversation to be clear about people’s realistic preferences within the context of their own priorities, so is a more supportive approach to challenging decisions about supporting people to live well with their long-term conditions. The ReSPECT process provides a framework for considering CPR decision making as part of an overall treatment plan, thus enabling emergency care planning to begin earlier, which enables the process to be opened out to more individuals earlier in their care journey. This is a more inclusive approach to the recording of a DNACPR status than previous practice. Evidence in areas using ReSPECT shows that, if done well, the process increases patient/carer involvement in discussions and decision making. It is well-aligned to the [Realistic Medicine](https://learn.nes.nhs.scot/24729/realistic-medicine/realistic-conversations-shared-decision-making-in-practice) approach to person centred care and shared decision making.
3. The ReSPECT process focuses on planning ahead for emergency situations and results in summary guidance to enable clinicians to rapidly inform their clinical decision-making when the patient is unable to express their preferences. Some similar approaches to wider ACP rely upon forms or conversation prompts that are too lengthy, often proving a challenge even for people in relatively good health to complete. For those not in good health or socially isolated with no one to help them complete the process, the barrier to participation may be insurmountable.
4. The ReSPECT process provides a succinct summary plan. This is both a clinical necessity and seen as being responsive to people’s needs and abilities to complete this type of process. A digital approach – for those for whom digital is the preferred channel – to ReSPECT is likely to further enhance this aspect.
5. An examination of the demographic of health service users in the NHS Forth Valley area revealed a population without much diversity of ethnicity. The feeling was that ReSPECT was covering a somewhat representative sample of the local population, with an expected bias towards elderly people. As implementation develops the sample will change towards those people earlier in their journey of living with long term conditions.
6. There was a sense that more articulate, affluent people were more likely to know about proactive approaches to care planning, such as ReSPECT. A marker for this was greater uptake of Power of Attorney to designate a representative to act on a person’s behalf at times of incapacity. This may be truer for people in a community setting, as the main drivers in the hospital setting remain clinical need based on those most at risk of deterioration. Uptake may also rely on adoption of the ReSPECT process by the clinician looking after patient.
7. A barrier to uptake in a primary care setting is the current paper process, meaning that the digital process may open this out where this barrier reduces engagement with the ReSPECT tool.
8. Given that the population included in the initial implementation were either towards the end of life or living with complex long terms conditions, access to service issues (beyond these awareness issues) along the lines of Tudor Hart’s [Inverse Care Law](https://www.kingsfund.org.uk/publications/articles/inverse-care-law) might need further exploration. Care plans of this type are often instrumental in prolonging life or maintaining wellbeing, depending on people’s preference, so there may be a sense access issues for wider ACP work do not manifest as strongly for ReSPECT.

**Supporting shared decision-making conversations**

1. Forth Valley has adopted different approaches to using the ReSPECT form to guide conversations. Some practitioners have opted to walk people through the form, section by section, while others have chosen to have a more open, unstructured conversation which is then recorded afterwards using the form headings. It is likely that this blended approach will remain when a digital solution is implemented, with digital viewed as an enabler rather than a driver. However, the form itself was very intentionally designed to prompt and support the conversation so it is essential that the digital view holds true to this design intention.
2. There was an overall view that any digital solution was simply part of a spectrum of different formats offered to support the conversation, based on people’s preferences.

**Digital inequalities**

1. Much of the existing evidence in relation to digital equalities relates more strongly to socio-economic factors – income, status, access to technology devices such as smartphones etc – and location-based factors – network coverage in remote/rural areas (and for ambulances in transit), broadband availability, service accessibility – and digital skills and usage, such as the Office of National Statistics figures outlined above.
2. There is considerable socio-economic diversity across the Forth Valley population. This likely has an impact on access to care planning services and will need careful consideration as the digital solution is implemented. Along with other social determinants of health, this is important territory for NDS’ wider equalities work to explore.
3. It has been an important part of the development of the ReSPECT product to ensure that the user interface support clinicians to efficiently access the information they need to best support the people they are working with in a clear and safe way. This has led to careful consideration of how information is presented, with an accessibility audit revealing key areas that were addressed in product development. In addition, wider design standards from the [Government Digital Service](https://design-system.service.gov.uk/) and [the NHS digital service manual](http://beta.nhs.uk/service-manual) have been adopted to ensure clarity and consistency of experience, as well as the high-quality accessibility.
4. The initial phases of ReSPECT product delivery are with digitally skilled clinical teams, keen to move away from paper processes, so the implementation of the application should have a positive impact. In wider roll-out ‘late adopters’ may introduce inequality for their patients and this challenge is a key consideration for good uptake of the application.
5. Such service improvements are part of wider health system improvement goals, as a recent European Commission paper on [Digital Transformation](https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/022_digitaltransformation_en.pdf) says:

“Attainment of the broad health system goals, including quality, accessibility, efficiency and equity, are objectives against which to judge new digital health services. These goals are unaltered by the process of digitalisation.”

1. However, it seems unlikely that ‘unaltered’ is the correct formulation, as there is emerging evidence of greater complexity to consider.
2. The interplay between digital and health inequalities has been identified as both a potential solution, but often a potential problem for health inequalities. Meta-analyses such as [Latulippe et al](https://www.ncbi.nlm.nih.gov/pubmed/28450271) are clear that many previous digital health solutions have contributed to the widening of the divide between those at risk of social health inequalities and the rest of the population.
3. Very recently [published research](https://academic.oup.com/eurpub/article/29/Supplement_3/13/5628050) (November 2019) by Azzopardi-Muscat and Sorensen is stronger in cautioning of digital transformation programmes to address the issue of health inequality directly in their design to stem the flow of exacerbations of inequalities that most digital transformations have brought, particularly associated with increased age, lower level of educational attainment and lower socio-economic status.
4. This highlights that this area is likely more nuanced than to say that health system goals are unaltered by the process of digitisation. Given the context of the Fairer Scotland Duty, which places a legal responsibility on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage, this will be a key consideration for the wider work of NDS.

**Service design**

1. A service design approach – aligned with the [Scottish Approach to Service Design](https://resources.mygov.scot/guidelines/service-design/guide/) – has been adopted across NDS and for the ReSPECT process specifically. This ensures inclusive, user-centred approaches to involving those directly impacted upon by the implementation of the new product in its design and delivery. This should ensure that the ReSPECT product does not contribute to the potential for digital to widen health inequalities. Continuing to mitigate against this factor is a key element of wider equalities activity across NDS products.
2. But additional [recently published research](https://www.thelancet.com/journals/landig/article/PIIS2589-7500%2819%2930194-3/fulltext?dgcid=raven_jbs_etoc_email) suggests that even when careful and inclusive design approaches are taken, there is still potential for significant challenges, particularly with elderly and ageing populations.
3. An approach to ensuring that products and services are created in greater alignment with equality and diversity needs has been developed by Doteveryone. The approach is called [Consequence Scanning](https://www.doteveryone.org.uk/project/consequence-scanning/). It has been designed to be adopted into everyday Agile development practice. Following conversations with contacts at Doteveryone, this has been implemented into NDS product development processes.

**4. Actions taken or planned in response to issues identified in the analysis**

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| **Issue identified** | **Action to be taken in response to issue** | **Responsibility** | **Timescale (indicate whether actions have already been completed, or provide timescale for carrying out the action)** | **Resources required** | **What is the expected outcome?** |
| Need to ensure accessibility standards met | Accessibility audit undertaken, with action plan documented and implemented | ReSPECT development team | COMPLETED November 2019 | Development time – factored into product management | Product fully meets accessibility standards |
| Need to embed equality and diversity thinking into agile product management practices | Consequence Scanning approach – developed by Doteveryone – adopted into agile development processes | ReSPECT product manager | ONGOING – initiated in November 2019 as a continuous improvement practice | Documentation of approach available online from Doteveryone; adoption into practice has been factored into team planning | Equality considerations become an everyday part of NDS product development |
| Need to consider the wider issues of how digital solutions and health inequalities interact – particularly the impact of wider socio-economic factors on care planning – to guard against a ‘double inequality’ | Planned workshop with the NHS Scotland Equality & Diversity leads to co-design the wider NDS approach to equalities | NDS team | Date being identified for January/February 2020 to initiate this work | Time identified within NDS staff roles to progress the work; supporting resources will need scoped | An approach to embedding equalities thinking across all NDS work is developed and implemented  |
| There is potential to explore through research the interaction between digital solutions – such as home monitoring devices – and the Inverse Care Law | Discussions have taken place with clinical colleagues to consider the development of a research paper on this topic | NDS team | Throughout 2020 | There is a need for expert clinical research input, so this needs to be identified | More detailed investigation of this potentially complex interaction to better inform action to address inequalities |
| The user interface of the ReSPECT digital solution presents problems for clinicians in safely accessing information | Government Digital Service standards adopted; full accessibility review undertaken | NDS team | Initial review COMPLETED (with ongoing actions identified) | Development time – factored into product management | Product fully meets accessibility standards |

**5. Risk Management**

1. In this assessment, have you identified any equality and diversity related risks which require ongoing management? If so, please attach a risk register identifying the risks and arrangements for managing the risks.
2. High-level risks and mitigations have been identified, summarised below:

* The ReSPECT application fails to meet user needs due to accessibility issues.

**Mitigation** – accessible design principles adopted into application development.

**Mitigation** – actions from accessibility review implemented

* Users of the ReSPECT application do not have the required digital skills to use the application

**Mitigation** – user-focussed design principles adopted into application development.

**Mitigation** – digital skills of users assessed with training and support made available to all to ensure equity of access.

* The digital solution to support ReSPECT undermines current positive experiences around the implementation of the ReSPECT process in Forth Valley

**Mitigation** – user-focussed design principles adopted into application development in collaboration with the Forth Valley team

**Mitigation** – a culture of health literacy responsiveness is well-embedded in Forth Valley

* The user interface of the ReSPECT digital solution presents problems for clinicians in safely accessing information

**Mitigation** – product developed to design and accessibility standards

**Mitigation** – ongoing approach to development and refinement of the ReSPECT product, based on user feedback

* Equality or health inequality issues are exacerbated by the implementation of the ReSPECT application

**Mitigation** – ‘consequence scanning’ approach adopted into application development.

**Mitigation** – consider more detailed research work on this topic, working with clinical colleagues.

**6. Consideration of Alternatives and Implementation**

1. The accessibility review led to changes to the coding of the ReSPECT application. With these changes made, no additional alternatives or changes to the proposed implementation were identified.
2. ReSPECT is currently running as a paper-based process – prior to implementation of the digital product – so will continue to be available in this way, based on people’s preferences.

**7. Monitoring and Review**

1. This EQIA for ReSPECT is the first documented output from NDS’ wider programme of equalities activity. It sits as part of the NDS compliance approach, which documents various aspects of impact activity (clinical safety review, data protection impact assessment, system security protocol etc) to ensure that NDS products meet a series of quality criteria.
2. Both the compliance and equalities strands are ongoing parts of NDS activity, with continuous improvement, regular monitoring and review a core part of the work.
3. In terms of data, the initial approach to collection will focus on the qualitative experience of implementation with the NHS Forth Valley clinical teams involved.
4. Incrementally, quantitative measures will be considered for adoption. These will include the development of commonly agreed metrics around uptake and diversity of those using the ReSPECT process to better inform the citizen-facing aspects of the product due to be delivered as part of phases 3 and 4 of the rollout.
5. Continuous monitoring against standards (such as accessibility) will be undertaken as part the product release strategy. In terms of roles and responsibilities for ongoing review, there will be input from the NDS compliance manager, the ReSPECT product manager, and the NDS equalities team.
6. The ReSPECT form is subject to regular review by the Resuscitation Council (UK). We are developing approaches to ensure we can regularly inform and contribute to this review process, which will include learning the lessons from implementation in other sites across the UK. This will also inform considerations on the balance between the digitally enabled version of ReSPECT and continued use of paper processes, to support health literacy responsive accessibility.

**Sign off (by accountable director):**

**Geoff Huggins**

27 February 2020

**ANNEX A**

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| **NHS Forth Valley Standard Impact Assessment Document (SIA)**Please complete electronically and answer all questions unless instructed otherwise.  |  |
| **Q1**: **Name of EQIA being completed i.e. name of policy, function etc.** |
| NHS FV ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Business Case 2019 |
| **Q1 a; Function [ ]  Guidance [ ]  Policy [ ]  Project x[ ]  Protocol [ ]  Service [ ]  Other, please detail** |
| **Q2:What is the scope of this SIA** |
| NHSFV Wide | x | Service Specific | [ ]  | Discipline Specific | [ ]  | Other (Please Detail) | [ ]  |
|  | Business Case |
| **Q3:Is this a new development? (see Q1)** |
| Yes | [x]  | No | [ ]  |
| **Q4:If no to Q3 what is it replacing?** |
|  |
|  |
| **Q5: Team responsible for carrying out the Standard Impact Assessment? (please list)** |
| NHS FV ReSPECT Implementation Group (Palliative Leads) |
|  |
| **Q6: Main person completing EQIA’s contact details** |
| Name: | Lynsey Fielden | Telephone Number:  | 01324 566 000 |
| Department: | Ageing and Health | Email:  | lfielden@nhs.net |
|  |
| **Q7: Describe the main aims, objective and intended outcomes**  |
| Aim: to ensure the safe and high quality transition to ReSPECT, removing the need for DNACPR, and increase person centred anticipatory care planning for the FV populationObjectives:* To integrate ReSPECT in to all care settings, removing need for DNACPR
* To allow this transition to take place and maintain high quality, safe and effective care (in line with the highest standard of care)
* To reduce unwanted variation in practice, reducing under and overtreatment
* To provide an excellent patient and carer experience
* To increase person centredness and shared decision making within anticipatory care planning and capture ‘What Matters to You’
* To identify patients earlier who may be in need of emergency/anticipatory care planning
* To provide care closer to home where possible (whilst ensuring that interventions are carried out in the right clinical environment)
* To minimise hospital stay
* To provide a robust workforce model, to ensure we have the right staff, with the right skills working in the right location to deliver on the realistic goals of care.
* To ensure the project is adequately resourced for the transition period
* To support the e-health/digital part of the project and support the roll out and education of the workforce to deliver this

Intended outcome:* Increase in % of patients with ReSPECT who have been identified for ACP or with ReSPECT triggers
* All patients in a care home or being discharge back to care home will have an ACP and CPR decisions will be recorded within a ReSPECT document.
* All care settings will be using ReSPECT and DNACPR will be removed
* No increase in cardiac arrest calls during this transition
* Increased % time at home in the last 6 months of life
* Earlier identification of patients with palliative and end of life care needs.
 |
| **Q8:** **(i)Who is intended to benefit from the function/service development/other (Q1) – is it staff, service users or both?** |
| Staff [x]  | Service Users [x]  | Other [ ]  Please identify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **(ii)** Have they been involved in the development of the function/service development/other? |
| Yes [x]  | No [ ]  |
| **(iii)** If yes, who was involved and how were they involved? If no, is there a reason for this action? |
| Comments:ReSPECT was developed with wide stakeholder engagement and is endorsed by the Resuscitation Council. We have conducted an early evaluation which has included patient, carer and staff feedback which has shaped the development of this project. We have presented out work to local health and social care sectors and performed public engagement days. |
| **(iv**) Please include any evidence or relevant information that has influenced the decisions contained in this SIA; (this could include demographic profiles; audits; research; published evidence; health needs assessment; work based on national guidance or legislative requirements etc)  |
| Comments:There are a number of studies or reports that have developed this work. These include: * Quantitative and Qualitative Evaluation of ReSPECT. NHS FV. Available on SPSP Deteriorating Patient webpage.
* Realistic Medicine reports
* Strategic Framework for Action on Palliative and End of Life Care
* Perkins GD, Griffiths F, Slowther AM, George R, Fritz Z, Satherley P, et al. Do- not-attempt-cardiopulmonary-resuscitation decisions: an evidence synthesis. Health Services and Delivery Research. 2016. Available from: https://www.ncbi.nlm.nih.gov/pubmed/27077163
* TheResuscitationCouncil(UK).RecommendedSummaryPlanforEmergency Care and Treatment (ReSPECT) 2018Available from: https://www.respectprocess.org.uk/
* NHS Forth Valley. ‘Shaping the Future’ NHS Forth Valley Healthcare Strategy 2016 - 2021

There has been growing evidence that DNACPR documentation is associated with negative connotations, distress, complaints, poor care and litigation. Locally, we continue to respond to complaints in relation to DNACPR documentation including Care Opinion. During an external board review, ReSPECT was also identified as being good for patients and it was felt this should be rolled out more broadly.  |
| **Q9: When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010 see below**: In summary, those subject to the Equality Duty must have due regard to the need to: * eliminate unlawful discrimination, harassment and victimisation;
* advance equality of opportunity between different groups; and
* foster good relations between different groups

Has your assessment been able to demonstrate the following: Positive Impact, Negative / Adverse Impact or Neutral Impact? |
| **What impact has your review had on the following ‘protected characteristics’:**  | **Positive** | **Adverse/****Negative** | **Neutral** | **Comments****Provide any evidence that supports your conclusion/answer for evaluating the impact as being positive, negative or neutral (do not leave this area blank)** |
| **Age** | x |  |  | Increasing anticipatory care planning with a person centred document will ensure that older people are at the centre of their care and is contributing to better outcomes.  |
| **Disability (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment)** | x |  |  | ReSPECT identified communications needs and mental incapacity and promotes the involvement of that person and key individuals in care planning. |
| **Gender Reassignment**  |  |  | x | No impact |
| **Marriage and Civil partnership**  |  |  | x | No impact |
| **Pregnancy and Maternity** |  |  | x | Not included in this work. |
| **Race/Ethnicity** |  |  | x | No impact |
| **Religion/Faith** | x |  |  | Considers ‘What Matters to You; and records any spiritual or cultural preferences. |
| **Sex/Gender (male/female)** |  |  | X | No impact |
| **Sexual orientation**  |  |  | x | No impact |
| **Staff (This could include details of staff training completed or required in relation to service delivery)** | x |  |  | ReSPECT will support staff in delivering the right care, at the right time in the right place as evidenced by our feedback. |

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| **Cross cutting issues: Included are some areas for consideration. Please delete or add fields as appropriate. Further areas to consider in Appendix B** |
| Carers | x |  |  | Carers will feel more empowered as they will know what the person preferences are for care, this has already been feedback. |
| Homeless | x |  |  | Vulnerable groups will be better able to record their wishes. |
| Involved in Criminal Justice System | x |  |  | Prisoners can go through the ReSPECT process and record their wishes.  |
| Language/ Social Origins | x |  |  | Interpreters have been utilised to complete ReSPECT, therefore this should not be considered a barrier. |
| Literacy  | x |  |  | Patient info leaflets are user friendly and consider literacy needs. Paper forms will still exist alongside digital.  |
| Low income/poverty | x |  |  | ACP will be targeted for those in greatest need irrespective of socioeconomic status, prioritisation is based on clinical need using trigger tool for identification.  |
| Mental Health Problems | x |  |  | Patients with mental health issues are a key focus in ReSPECT engagement.  |
| Rural Areas | x |  |  | Access to ReSPECT in a digital form can mean easier access to care planning. |
| Armed Services Veterans, Reservists and former Members of the Reserve Forces |  |  | x | No impact |
| **Q10: If actions are required to address changes, please attach your action plan to this document. Action plan attached?** |
| Yes | [ ]  | No | [x]  |
|  |
| **Q11**: **Is a detailed EQIA required?** |
| Yes | [ ]  | No | [x]  |
| Please state your reason for choices made in Question 11.ReSPECT and ACP will actually open up discussions for people who are vulnerable and ordinarily be at risk of feeling excluded. ReSPECT is particularly useful in identifying any unique needs e.g. cultural, spiritual and in some vulnerable populations. The screening process has not shown potential for a high negative impact. The business case does not have a significant impact upon equality issues. A detailed impact assessment is not required at this stage. |
| N.B. If the screening process has shown potential for a high negative impact you will be required to complete a detailed impact assessment. |

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| **Date EQIA Completed** | 13 / 05 / 2019 |  |  |
| **Date of next EQIA Review** | 13/ 05 / 2020 |  |  |
| **Signature** | LA Fielden | Print Name | Lynsey Fielden |
| **Department or Service** | Public Health & Planning |  |  |

Please keep a completed copy of this template for your own records and attach to any appropriate tools as a record of SIA or EQIA completed. Send copy to leigh.fagan@nhs.net

##### If you have any queries please contact lynn.waddell@nhs.net

Or call Lynn on 01324 614653

##### B: Standard/Detailed Impact Assessment Action Plan

|  |  |
| --- | --- |
| **Name of document being EQIA’d:** | **ReSPECT business plan** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Issue** | **Action Required** | **Lead (Name, title, and contact details)** | **Timescale** | **Resource Implications** | **Comments** |
| DD / MM / YYYY |  |  |  |  |  |  |
| DD / MM / YYYY |  |  |  |  |  |  |
| DD / MM / YYYY |  |  |  |  |  |  |
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| Further Notes: |  |

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| --- | --- | --- | --- |
| Signed: |  | Date: |  |

###### C: Quality Assurance – Policies and Guidance only

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| --- |
| QA Section |
|  |
| Lead authors details? |
| Name:  |  | Telephone Number:  |  |
| Department:  |  | Email:  |  |
|  |
| Does your policy / guideline / protocol / procedure / ICP have the following on the front cover? |
| Version Status | [ ]  | Review Date | [ ]  | Lead Author | [ ]  |
| Approval Group | [ ]  | Type of Document (e.g. policy, protocol, guidance etc) | [ ]  |
|  |
| Does your policy / guideline / protocol / procedure / ICP have the following in the document? |
| Contributory Authors | [ ]  | Distribution Process | [ ]  | Implementation Plan | [ ]  |
| Consultation Process | [ ]  |  |  |  |  |
|  |
| Is your policy / guideline / protocol / procedure / ICP in the following format? |
| Arial Font | [ ]  | Font Size 12 | [ ]  |  |  |
|  |
| Signatures |
|  |
| Lead Author: |  | Date: | DD / MM / YYYY |

1. In this document, 'function' is used broadly to cover all the areas of work for which impact assessment is required, as defined in the Regulations. This includes policy, programme, project, service and function, among others. [↑](#footnote-ref-2)